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Office of Administrative Law Judges
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Issue Date: 27 January 2006

In the Matter of:

RONNNIE S. THOMAS,
Claimant

v.

BARTON MINING, INC.,
Employer

and

LIBERTY MUTUAL INSURANCE CO.,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Case No. 2004-BLA-6170

Appearances:

Ron Carson, Lay Representative
Stone Mountain Health Services
St. Charles, Virginia
For the Claimant

H. Ashby Dickerson, Esq.
Penn Stuart
Abingdon, Virginia
For the Employer and Carrier

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER GRANTING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq. The Act and implementing regulations, 20 CFR Parts 410, 718, 725 and 727, provide compensation and other benefits to living coal miners who are totally disabled due

to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2005). In this case, the Claimant, Ronnie Thomas, alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing on this claim on October 26, 2004, in Abingdon, Virginia. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2005). At the hearing, the Claimant was the only witness. Transcript ("Tr.") at 18. Director's Exhibits ("DX") 1-43 and Claimant's Exhibits ("CX") 1-6 were admitted into evidence without objection. Tr. at 6 and 9.

At the hearing, Employer offered exhibits 1 through 8. *Tr.* at 11-13. However, after discussion on the record, Employer withdrew Employer's Exhibit 7, which consisted of a rebuttal interpretation to a chest x-ray study that Claimant chose not to submit in support of its affirmative case. Although the Claimant did not object to admission of Employer's Exhibits 1 through 6 and 8, they were not formally admitted as evidence at the hearing. *Tr.* at 13-14. As the exhibits comply with the evidentiary limitations at 20 CFR § 725.414 and Claimant did not object, they are hereby admitted into the formal record.

At the hearing, I also granted the parties' request that the record be left open to give Employer the opportunity to respond to certain Claimant's Exhibits, which had been exchanged less than 20 days prior to the hearing. *Tr.* at 9. I further concluded that the record would be held open to permit Claimant the opportunity to have the April 30, 2003 chest x-ray study reread. *Tr.* at 10-11.

I hereby admit the following additional exhibits, which have been submitted timely by the parties: CX 7, which is Dr. Afzal Ahmed's rereading of the April 30, 2003 chest x-ray study; EX 9, which is Dr. Sarah Long's evaluation of the February 10, 2004 pulmonary function study; and EX 10, which is Dr. Larry Westerfield's interpretation of the March 4, 2004 chest x-ray study. Claimant's Exhibit 8, which had been submitted post-hearing, was excluded by my *Order* dated March 10, 2005 as it exceeded "the scope of the post-hearing submissions discussed at the hearing." The Employer submitted a revised closing argument on March 15, 2005. No other party submitted a closing statement and the record is now closed.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits admitted into evidence, the testimony at hearing and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed his initial claim on June 3, 1997. DX 1. The claim was denied by the District Director of the Office of Workers' Compensation Programs ("OWCP") on July 15, 1997, on the grounds that the evidence did not show that the Claimant had pneumoconiosis, or

that it was caused by coal mine work, or that the Claimant was totally disabled due to the disease.[1] The Claimant did not appeal that determination. DX 1.

More than one year later, on July 10, 2002, the Claimant filed a subsequent claim. The subsequent claim was granted by *Proposed Decision and Order* of the District Director on September 3, 2003. DX 36. The Employer appealed on September 29, 2003. DX 38. The claim was referred to the Office of Administrative Law Judges for hearing on April 20, 2004. DX 41.

APPLICABLE STANDARDS

This claim relates to a "subsequent" claim filed on July 10, 2002. Because the claim at issue was filed after March 31, 1980, and after January 19, 2001, the effective date of the current regulations, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2005). Pursuant to 20 CFR § 725.309(d) (2005), in order to establish that he is entitled to benefits, the Claimant must demonstrate that "one of the applicable conditions of entitlement … has changed since the date upon which the order denying the prior claim became final" such that he now meets the requirements for entitlement to benefits under 20 CFR Part 718. In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203 and 718.204 (2005). I must consider the new evidence and determine whether the Claimant has proved at least one of the elements of entitlement previously decided against him. If so, then I must consider whether all of the evidence establishes that he is entitled to benefits. *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358 (4th Cir. 1996).

ISSUES

There are no issues contested by the Director. However, the issues contested by the Employer are:

1. Whether the Claimant has pneumoconiosis as defined by the Act and the regulations.

2. Whether his pneumoconiosis arose out of coal mine employment.

3. Whether he is totally disabled.

4. Whether his disability is due to pneumoconiosis.

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[1] Notably, the denial format used by the District Director combined the elements of (1) whether the miner suffered from a totally disabling respiratory impairment, and (2) if so, whether the impairment arose from coal dust exposure. Although the Department-sponsored examination was conducted by Dr. Iosif, who concluded that the miner did suffer from a totally disabling respiratory impairment that was unrelated to coal dust exposure, I am confined by the District Director's final decision in the miner's initial claim; *to wit*, Claimant failed to establish any element of entitlement.

5. Whether the evidence establishes that one of the applicable conditions of entitlement has changed pursuant to 20 CFR § 725.309 (2005).

DX 41; Tr. at 5. The Employer also reserved its right to challenge the statute and regulations. Tr. at 5-6. At the hearing, the parties agreed that the Claimant worked in or around the coal mines for 23 years. Tr. at 14; DX 41.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

Claimant's last coal mine employment was in the Commonwealth of Virginia**.** DX 4. Therefore, this claim is governed by the law of the Fourth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc).

Claimant testified that he was born in1950; he was 53 years old at the time of the hearing. *Tr.* at 18. He is five feet, eight inches tall. *Tr.* at 19.

Claimant last engaged in coal mine employment in July 1993. *Tr.* at 19. At that time, he had worked for Barton Mines for three years and his last usual job had been as a roof bolter. *Tr.* at 19. Claimant described his last job as follows:

> We drilled the top and put bolts in it to keep the top from coming down. To hold it up, support it.

Tr. at 19. He further testified:

> We run a roof bolter. And it's double-manned. Two men operate it. It has a head on each side and they go up and nail the plates where we put two bolts apiece on each side and move to another row and put two more bolts apiece.

Tr. at 20. Claimant recalled that the bolts weighed one or two pounds each and he would insert 150 to 200 bolts per shift. *Tr.* at 20. Claimant testified that the last area in which he worked was 40 inches high and he had to bend over while working. *Tr.* at 21. Claimant also had to crawl during his shift. *Tr.* at 21. The job was dusty and he did not wear a respirator. *Tr.* at 19-20.

Claimant stated that he stopped working in 1993 because he "couldn't breathe good." *Tr.* at 21. When asked how long he had noticed his breathing problems, Claimant replied:

> I had it when I was working for them. We were in a lot of water at another mine. And I thought it was the water keeping me sick. It must have been when I was coming down with this.

Tr. at 21.

Claimant has been treated by Dr. J.P. Sutherland since 1994. *Tr.* at 22. He has been on oxygen 24 hours per day since he was hospitalized for pneumonia in February 2003. *Tr.* at 23.

Claimant testified that he started smoking when he was about 14 years of age. *Tr.* at 27. He has smoked about one pack of cigarettes per day and continues to smoke. *Tr.* at 27. The Claimant testified on cross-examination that he is on oxygen 24 hours a day and turns off the oxygen when he smokes. *Tr.* at 28.

Material Change in Conditions

In a subsequent claim, the threshold issue is whether one of the applicable conditions of entitlement has changed since the previous claim was denied. The Claimant's previous claim was denied by the District Director on July 15, 1997, and the denial became final one year later. According to his testimony, he stopped working altogether in July 1993 because of breathing difficulties. As will be discussed in more detail below, pulmonary function tests and medical reports indicate that he now has a pulmonary impairment which is totally disabling. This constitutes a material change in conditions. Because the new evidence establishes that a material change in conditions has occurred, I must consider all of the evidence in the record in reaching my decision whether he is now entitled to benefits. Evidence admitted in the prior claim may be considered notwithstanding the limitations on the introduction of evidence contained in 20 CFR § 725.414 (2005). 20 CFR § 725.309(d)(1) (2005). Moreover, no findings in the prior claim are binding, unless a party fails to contest an issue, or made a stipulation in a prior claim. 20 CFR § 725.309(d)(4) (2005).

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in connection with the current claim.

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2005). Any such readings are therefore included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, given in connection with medical treatment or review of an x-ray film solely to determine its quality, are listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations.[2] Qualifications of physicians are abbreviated as follows: B= NIOSH certified B reader and BCR= board-certified in radiology. Readers who are board-certified radiologists and/or B readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be radiologists.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
12-10-02	DX 32 Ahmed B, BCR 1/0, s/p All six lung zones	EX 8 Scott B, BCR No parenchymal or pleural abnormalities consistent with pneumoconiosis	
01-15-03	DX 15 Patel B, BCR 1/0, s/t Lower four lung zones	DX 31 Scatarige B, BCR "Hyperinflation of lungs (consistent with) emphysema or deep breath"; "No evidence of cwp/silicosis"	DX 16 Navani B, BCR Quality reading only. Film Quality: 1
03-12-03	DX 32 Miller B, BCR 1/0, s/t All six lung zones	EX 1 Scott B, BCR No parenchymal or pleural abnormalities consistent with pneumoconiosis; "hyperinflation of lungs: deep breath versus emphysema"	
04-30-03	CX 7 Ahmed B, BCR 1/0, s/t All six lung zones.	DX 33 Halbert B, BCR Film marked as "completely negative"	

[2]NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, List of NIOSH Approved B Readers with Inclusive Dates of Approval [as of] June 7, 2004, found at http://www.oalj.dol.gov/public/blalung/refrnc/bread3_07_04.htm. Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www.cdc.gov/niosh/topics/chestradiography/breader-list.html. Information about physician board certifications appears on the web-site of the American Board of Medical Specialties, found at http://www.abms.org.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
12-04-03		EX 5 Wiot B, BCR No parenchymal or pleural abnormalities consistent with pneumoconiosis	
03-02-04		EX 10 Westerfield B "Negative for parenchymal of pleural abnormalities to suggest pneumoconiosis/asbestosis"; Findings of "underlying mild COPD and emphysema"	

X-ray interpretations from the prior claim appear on the following chart:

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
05-27-97		DX 1 Gaziano B Film marked as "completely negative" DX 1 Forehand B Film marked as "completely negative"	

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

The following chart summarizes the results of the pulmonary function studies available in connection with the current claim. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2005).

Ex. No. Date Physician	Age Height[3]	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 11 01-15-03 Rasmussen	52 67”	0.73 0.81	2.48 2.95	29% 27%	27 29	Yes Yes	Very severe, slightly reversible obstructive ventilatory impairment. Maximum breathing capacity markedly reduced. Residual volume markedly increased. Total lung capacity moderately increased. Dr. Michos concluded that the study was valid. DX 13.
DX 32 03-12-03 Narayanan	52 68”	0.88	3.18	27.6%	--	Yes	Very severe obstruction. “COPD risk 100%. If stop smoking, 99%.” DX 32.

[3] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the miner from 66.5” to 68”, I have taken the mid-point (67.25”) in determining whether the studies qualify to show disability under the regulations.

Ex. No. Date Physician	Age Height[3]	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 33 04-30-03 Rosenberg	52 68”	0.71 0.77	3.01 2.95	23.5% 26%	27 28	Yes Yes	Per Dr. Mettu, very severe obstructive airway disease. Mild improvement in post-bronchodilator studies. Lung volumes are consistent with obstructive airway disease.
EX 3 12-04-03 Fino	52 66.5”	0.60	2.93	20.4%	--	Yes	Good effort and cooperation. Bronchodilator not given, patient used Combivent one hour prior to testing. EX 3.
CX 1[4] 02-10-04 Narayanan	53 68”	0.55	1.88	29.2%	--	Yes	Severe obstruction as well as low vital capacity, possibly from a concomitant restrictive defect. CX 1.

[4] By undated letter, Dr. Sarah B. Long evaluated the February 10, 2004 pulmonary function study and concluded that it was not valid. EX 9. She stated the following:

> There are three flow volume loops. The recording of these is so small that it is not possible to evaluate the loops. There are three spirometric tracings. These are recorded at 10 mm/sec. instead of 20 mm/sec. required by Federal Black Lung Regulations. The initial slope of all of the curves is extremely shallow. This indicates less than optimal effort in performing the study. There is one MVV tracing. The tidal volumes are very small indicating less than optimal effort.
>
> This pulmonary function study is not valid per Federal Black Lung Regulations due to the less than optimal effort in performing the study. There are also other deficiencies as noted above. This pulmonary function study would not be useful in the evaluation of a respiratory impairment.

EX 9.

The following chart summarizes the results of the pulmonary function studies available in connection with the prior claim.

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 1 06-10-97 Iosif	46 68”	1.12 1.19	3.06 3.61	36.6% 32.9%	--	Yes Yes	Not clearly improved post bronchodilator. Severe obstruction. Mild chest restriction. Low FEV0.5 suggests poor initial effort. DX 1. By report dated June 30, 1997, Dr. Ranavaya validated the test. DX 1.

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

The following chart summarizes the arterial blood gas studies available in connection with the current claim. A “qualifying” arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2005).

Exhibit Number	Date	Physician	PCO_2 at rest/ exercise	PO_2 at rest/ exercise	Qualify?	Physician Impression
DX 10	01-15-03	Rasmussen	43 56	65 44	No Yes	Single breath carbon monoxide diffusing capacity markedly reduced. Minimal resting hypoxemia.
DX 33	04-30-03	Rosenberg	43.8 52.1	73.0 59.5	No Yes	DLCO severely decreased.
EX 6	06-23-03	Sutherland	47.0	74.7	No	
EX 4	12-04-03	Fino	50.8 52.9	70.0 64.5	Yes Yes	Hypoxemia with exercise and variable hypercarbia

The following chart summarizes the results of the arterial blood gas study available in connection with the prior claim.

Exhibit Number	Date	Physician	PCO_2 at rest/ exercise	PO_2 at rest/ exercise	Qualify?	Physician Impression
DX 1	06-10-97	Iosif	35.3	80.8	No	

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2005). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2005). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2005). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a

physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2005). The record contains the following medical opinions relating to this case.[5]

1. Dr. German Iosif examined and tested the miner in conjunction with the miner's first claim at the request of the Department and issued a report on June 10, 1997. DX 1. He reported 22 years of coal mine employment, where Claimant last worked as a roof bolter in 1993. The miner complained of "daily wheezing and 'chest rattling' for many years." He also had a productive cough at times. Dr. Iosif further noted that Claimant smoked one pack of cigarettes per day for over 30 years. Examination of the lungs revealed increased resonance on percussion, bilateral scattered wheezes on auscultation "which overall reduction in air movement." Cardiac examination produced normal findings. DX 1.

The miner had an elevated carboxyhemoglobin level of seven percent. DX 1. Ventilatory testing revealed severe airways obstruction. A chest x-ray was interpreted as completely negative. Dr. Iosif concluded that there was no evidence to support a diagnosis of pneumoconiosis:

> The history, respiratory physical findings, spirometries and chest x-ray are consistent with a diagnosis of severe Chronic Obstructive Pulmonary Disease, most likely a manifestation of pulmonary emphysema. Even though the resting arterial blood gases were normal, the degree of obstructive ventilatory defect is extreme and consistent with a totally disabling impairment.

Dr. Iosif concluded that the miner suffered from a totally disabling respiratory impairment that "is the likely result of long-lasting and ongoing cigarette smoking in an individual who appears to have a genetic or familial susceptibility to such conditions." DX 1.

Dr. Iosif is board-certified in internal medicine and pulmonary diseases.

2. Dr. Donald L. Rasmussen examined and tested the miner at the request of the Department in conjunction with his second claim and issued a report on February 21, 2003. DX 11. Dr. Rasmussen reported 22 to 23 years of coal mine employment, where the miner worked as a general inside laborer, motorman, scoop operator, and roof bolter. Dr. Rasmussen noted that Claimant's last job was roof bolter:

> He bent bolts in low coal. He pulled and hung heavy electrical cable. He set timbers when pillaring. Thus, he did considerable heavy manual labor.

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[5] Because, as will be discussed, the miner has established an element of entitlement previously adjudicated against him, I will include a summary of Dr. Iosif's medical opinion here even though it was developed in conjunction with the miner's prior claim.

Moreover, by letter dated October 14, 2004, Office Manager Gary Hartsock of the Social Security Administration (SSA) states that SSA found Claimant "disabled due to chronic pulmonary insufficiency." No further explanation or documentation was provided. As a result, this letter carries no probative value in determining any of the medical issues in this claim.

Dr. Rasmussen further reported that Claimant smoked one pack of cigarettes per day since 1966 and continues to smoke. DX 11.

He stated that the miner complained of productive cough, wheezing, dyspnea, paroxysmal nocturnal dyspnea, and chest pain, which was described as "[p]arasternal and substernal pain like a heavy weight, with exertion, relieved slowly (with) rest." DX 11. Examination of the lungs revealed breath sounds that were "moderately to markedly reduced." Moreover, Dr. Rasmussen noted "widespread expiratory wheezes with forced respirations." Cardiac examination produced findings of normal heart tones and regular rhythm with no murmurs, gallops, or clicks. DX 11.

A chest x-ray revealed the presence of Category 1 pneumoconiosis. DX 11. An EKG demonstrated "regular sinus rhythm and nonspecific ST-T wave changes." Pulmonary function testing produced findings of a "very severe, slightly reversible obstructive ventilatory impairment." The miner's maximum breathing capacity was markedly reduced, whereas the residual volume was markedly increased and the total lung volume was markedly increased. The single breath carbon monoxide diffusing capacity was markedly reduced. DX 11.

After an exercise study, Dr. Rasmussen noted that Claimant denied chest pain but was "unable to exercise beyond 1.4 mph at a 0% grade." DX 11. Claimant "exceeded his anaerobic threshold prematurely at approximately 24% of his weight adjusted predicted maximum oxygen uptake" and the miner's "heart rate was markedly excessive at 73% of predicted maximum." Dr. Rasmussen also noted that Claimant experienced a "very marked impairment in oxygen transfer with marked hypoxia." DX 11.

Dr. Rasmussen diagnosed coal workers' pneumoconiosis based on 22 years of coal mine employment and the chest x-ray. DX 11. He also concluded that Claimant suffers from coal dust-induced and tobacco-induced chronic obstructive pulmonary disease and emphysema based on the fact that the miner had a chronic productive cough, airflow obstruction, and "reduced SBDLCO." DX 11. Dr. Rasmussen opined that Claimant suffers from a "very marked loss of lung function" and does not retain the pulmonary capacity to perform his last job as a roof bolter. He stated that cigarette smoking and coal dust exposure each contributed to the miner's disability as both factors "share some of the same cellular and biochemical methods" in damaging lung tissue.

Dr. Rasmussen is board-certified in internal and forensic medicine. He was appointed to the NIOSH Coal Mine Health Research Advisory Committee from 1976 to 1979 and continued to serve under a variety of special appointments with the U.S. government and private sector entities related to coal mine health issues. He has testified before Congress on black lung disease and, in 1969, he was awarded the American Public Health Presidential Award for "exceptional service" in the area of black lung.

3. By letter dated April 30, 2003, the miner's treating physician, Dr. J.P. Sutherland, states that Claimant suffers from "severe restrictive and obstructive lung disease that requires oxygen therapy because of chronic hypoxia associated with chronic obstructive pulmonary disease." DX

32. Dr. Sutherland further reports that the miner "has inability to ambulate even short distances without severe wheezing and severe shortness of breath." Dr. Sutherland diagnosed restrictive and obstructive lung disease due to Claimant's 20 years of documented coal mining employment. He concludes that the miner is totally disabled due to coal dust induced chronic obstructive pulmonary disease. Dr. Sutherland reports that he has been treating the miner since 1994 and has prescribed inhalers Advair, Singulair, and Decadron– as well as "oxygen 2 liters per minute via nasal cannula on a 24 hour per day basis . . .." DX 32.

The record also contains Dr. Sutherland's progress and treatment notes from February 18, 2003 to February 24, 2004. CX 3. The notes reflect the following:

February 18, 2003: Claimant was seen as follow-up to his February 13, 2003 hospitalization for pneumonia. Cardiac examination produced normal findings. Examination of the lungs, however, yielded evidence of "coarse rhonchi with inspiratory stridor and expiratory wheeze with intercostal reactions." Dr. Sutherland noted that Claimant on oxygen 24 hours per day and that he used "a nebulizer machine with albuterol every 6 hours." Clubbing and cyanosis of the nail beds were also noted. Dr. Sutherland diagnosed acute bronchitis as well as emphysema with chronic obstructive pulmonary disease.

April 29, 2003: Claimant complained of shortness of breath. Again, cardiac examination was normal. Examination of the miner's lungs produced evidence of "coarse rhonchi with inspiratory stridor and expiratory wheeze with intercostal reactions." Severe wheezing was also reported. Dr. Sutherland noted "severe hyperation of all lung fields associated with increased AP diameter of the chest." Again, clubbing and cyanosis of the nail beds was reported. Dr. Sutherland diagnosed chronic bronchitis and emphysema as well as chronic hypoxia associated with restrictive and obstructive lung disease.

June 17, 2003: The miner continued to experience shortness of breath. Cardiac examination was normal whereas examination of the lungs revealed "fine rhonchi with inspiratory stridor and expiratory wheeze." Clubbing and cyanosis of the nail beds continued to be reported. Dr. Sutherland diagnosed chronic bronchitis and emphysema as well as "end stage lung disease" with chronic obstructive pulmonary disease.

October 14, 2003: Shortness of breath continued to be reported. Cardiac examination was normal. The lungs exhibited "fine rhonchi with inspiratory stridor and expiratory wheeze." Dr. Sutherland reported that Claimant "is on oxygen 2 liters per minute for end stage lung disease due to severe hypoxia." Clubbing and cyanosis of the nail beds were reported. Dr. Sutherland diagnosed acute bronchitis, emphysema, chronic obstructive pulmonary disease, pneumoconiosis with restrictive and obstructive lung disease, and bronchiectasis.

Dr. Sutherland graduated with a Doctor of Osteopathy from the West Virginia School of Osteopathic Medicine. He is actively engaged in an office-based family practice. CX 3 at 5.

As part of Claimant's treatment under the care of Dr. Sutherland, he was referred to Dr. Joseph Smiddy, a pulmonologist, for a consultative opinion. CX 2. The record contains the

March 2, 2004 consultative letter from Dr. Smiddy as well as his March 16, 2004 progress notes. CX 2.

Dr. Smiddy examined and tested the miner at the request of Dr. Sutherland and, in his March 2, 2004 letter, Dr. Smiddy noted that the miner had a "known cough, wheeze, shortness of breath, and production of white sputum." CX 2. He further stated that Claimant "had progressive exercise limitation." Dr. Smiddy also reported "a longstanding diagnosis of Coal Workers' Pneumoconiosis and (Claimant) worked in heavy coal dust over a 23 year time period." Dr. Smiddy reported that the miner started smoking at the age of 14 years and he continued to smoke at the time of the examination. CX 2.

Examination of the lungs revealed decreased breath sounds to auscultation. CX 2. No abnormal findings were noted on cardiac examination. A chest x-ray was brought from an outside source, but Dr. Smiddy found that it was "overpenetrated" and ordered another study. Dr. Smiddy concluded that the miner suffered from coal workers' pneumoconiosis, hypoxia, chronic obstructive pulmonary disease, and "[o]ngoing smoking and a downhill course." Dr. Smiddy noted that, in addition to a chest x-ray, a ventilatory study and exercise pulse oximetry had been ordered. CX 2.

In a follow-up progress note dated March 16, 2004, Dr. Smiddy reiterated that the miner suffered from coal workers' pneumoconiosis. Ventilatory testing revealed "very severe pulmonary disease." Dr. Smiddy noted that "[t]he patient has some restriction, profound obstruction, and reduced DLCO." Further, he stated that "[t]he patient's reduced DLCO is consistent with the fact that he requires oxygen supplementation." Notably, with regard to the chest x-ray interpretation, Dr. Smiddy states:

> We obtained a B-Reader chest x-ray at Holston Valley Hospital 03-02-04, which was read by Dr. Larry Westerfield, certified B-Reader, as negative for parenchymal or pleural abnormalities to suggest pneumoconiosis.

CX 2 at 5. Nevertheless, Dr. Smiddy concluded that "[i]t remains my opinion that this patient does have indeed significant Coal Workers Pneumoconiosis" and Claimant "does still smoke and was advised to stop smoking." CX 2.

Dr. Smiddy received his medical degree from the University of Virginia, where he was on the dean's list. He is board-certified in internal medicine. He is board-eligible in the sub-specialty of pulmonary diseases. He currently serves as Medical Director of the Lung Center at Holston Valley Hospital and Medical Center. Dr. Smiddy is also Medical Director of the Wound and Hyperbaric Program of Wellmont Health Systems at Holston Valley Hospital. He gives a variety of conferences, Grand Rounds, and seminars to medical staff and residents on topics including pneumoconiosis, chronic obstructive pulmonary disease, and asthma. He has been a contributing author to a medical book as well as a variety of other publications. Dr. Smiddy serves as Chair of the Occupational Lung Disease Committee at Holston Valley Hospital, which included lecturing to Washington and Lee School on Law students on the topic of black lung.

4. At Employer's request, Dr. David M. Rosenberg examined and tested the miner on April

30, 2003, conducted a review of certain medical records, and issued a report dated May 8, 2003. DX 33. Dr. Rosenberg noted that, at the time of his examination, Claimant had been on oxygen since February 2003. It was also noted that the miner complained of worsening breathing difficulties dating back to 1993 when "[h]e had to stop working . . . because of his respiratory condition." The Claimant reported cough and sputum production "on a regular basis" as well as wheezing. He reported sleeping on two pillows. Dr. Rosenberg further noted that the miner said "he would awaken at night with shortness of breath, without edema, hemoptysis, chest pains or palpitations." DX 33.

Dr. Rosenberg reported that Claimant "smoked cigarettes, starting at age 14 or 15, which continues at the present time despite wearing oxygen." DX 33. The miner noted that he smokes one half a pack of cigarettes per day "and probably averaged a pack of cigarettes/day over the years." Dr. Rosenberg further noted 23 years of coal mine employment, where the miner stopped working in 1993. He last worked as a roof bolter and "would have to lift up to 50 pounds." The miner recalled that "no respiratory protection was utilized." DX 33.

Examination of the lungs revealed "equal expansion of his chest, with marked hyperresonance and decreased breath sounds, scattered rhonchi and wheezes; he had no rales." DX 33. On cardiac examination, there were "no murmurs, gallops, or rubs . . .." A chest x-ray revealed emphysematous changes and chronic obstructive pulmonary disease. No "micronodular opacities of coal dust exposure and (coal workers' pneumoconiosis)" were noted. Ventilatory testing produced evidence of a severe airflow obstruction with no significant improvement after use of bronchodilators. Resting blood gas testing yielded non-qualifying values at rest and qualifying values after exercise. The carboxyhemoglobin level was 4.3 percent. Exercise testing was terminated when Claimant fell "markedly short of breath."

Dr. Rosenberg concluded that Claimant did not have any chest x-ray findings of coal workers' pneumoconiosis. DX 33. Further, he noted the absence of "persistent end-inspiratory rales" on auscultation, which militated against a finding of coal workers' pneumoconiosis. Dr. Rosenberg also stated:

> [H]is TLC was increased, which indicates he does not have restriction. While his diffusing capacity was significantly reduced, this relates to the presence of severe emphysema . . . and is not related to the interstitial form of coal workers' pneumoconiosis . . ..

DX 33. As a result, Dr. Rosenberg concluded that Claimant does not suffer from clinical coal workers' pneumoconiosis.

On the other hand, Dr. Rosenberg diagnosed the presence of severe, totally disabling chronic obstructive pulmonary disease. DX 33. He concluded that this condition was due to the miner's long-term tobacco abuse:

> There is no question that coal mine dust exposure can cause COPD, and begins in and around the coal macule as focal emphysema develops. Subsequently, as coal workers' pneumoconiosis becomes more severe with the macule evolving into

> nodule formation, the associated COPD also can become more significant. With respect to Mr. Thomas, it would be improbable that his disabling COPD relates to the inhalation of past coal dust exposure, as his chest x-ray reveals no evidence of coal workers' pneumoconiosis. In fact, even if he had a minimal degree of simple coal workers' pneumoconiosis, his advanced disabling COPD . . . would not have been caused by this CWP. This type of 'end-stage' COPD only is associated with past coal dust exposure, if complicated CWP exists.

DX 33.

Dr. Rosenberg is Medical Director of the University of Occupational Health Services at Chagrin Highlands University Hospitals of Cleveland. He also has a Master's Degree in Public Health and is board-certified in internal and preventative medicine.

5. At Employer's request, Dr. Gregory Fino examined and tested the miner, reviewed certain medical records, and issued a report on January 30, 2004. EX 2. Dr. Fino reported a history of smoking one pack of cigarettes per day since 1968 and continuing. He further noted 23 years of coal mine employment, ending in 1993 due to "shortness of breath." Dr. Fino stated that the miner last worked as a roof bolter, "which involved heavy labor." Claimant reported that he was "limited in what he can do because of his breathing" and, although he does not have chest pain, he does suffer from wheezing and a daily cough. Dr. Fino also noted that the miner was hospitalized for pneumonia and had a history of emphysema, bronchitis, bronchiectasis, frequent colds, and chronic stomach problems among other conditions. EX 2.

Examination of the lungs revealed "[d]ecreased breath sounds bilaterally" and "[b]ilateral wheezes." EX 2. Cardiac examination was normal. With regard to the chest x-ray, Dr. Fino noted his agreement with Dr. Wiot's classification as Category 0. Ventilatory testing yielded evidence of a severe obstructive ventilatory defect. Moreover, the Total Lung Capacity was elevated and "air trapping (was) present." Claimant also exhibited a reduced diffusing capacity and elevated carboxyhemoglobin level. Blood gas testing revealed no resting hypoxemia but, after exercise, there was evidence of "moderate resting hypercarbia which increased slightly with exertion." EX 2.

Dr. Fino concluded that Claimant suffers from severe pulmonary emphysema and chronic obstructive bronchitis related to cigarette smoking. He pointed to clinical findings of decreased breath sounds and wheezes, a severe fixed obstructive defect, reduced diffusing capacity, and marked increase in lung volumes as consistent with a diagnosis of emphysema. He further posits that "[t]he oxygen desaturation and hypoxemia with exercise in conjunction with variable hypercarbia are all consistent with cigarette smoking induced lung disease." Moreover, Dr. Fino concludes that the miner's tobacco-induced respiratory impairment is totally disabling. In determining that smoking caused the impairment, Dr. Fino states the following:

> Even if chronic obstructive lung disease due to coal mine employment contributed to the obstruction, the loss in the FEV1 would be in the 200 cc range. If we gave back to him that amount of FEV1, this man would still be disabled. This medical estimate of loss in FEV1 in working miners was summarized in the 1995 NIOSH

document. Although a statistical drop in the FEV1 was noted in working miners, that drop was not statistically significant.

EX 2. Dr. Fino concluded that, even if it was assumed that coal workers' pneumoconiosis was present, it did not contribute to Claimant's disability. EX 2.

Dr. Fino is board-certified in internal medicine as well as the sub-specialty of pulmonary diseases. EX 2. He is also a NOISH certified B-reader. Dr. Fino received his medical degree from the University of Pittsburgh School of Medicine. He is currently part of the Clinical and Occupational Pulmonary Associates, LLC and Critical Care and Pulmonary Associates, PC at St. Clair Hospital in Pittsburgh, Pennsylvania. Dr. Fino serves as a teaching instructor at the University of Pittsburgh's Division of Pulmonary Disease. He has been the contributing author of numerous publications related to pulmonary diseases. EX 2.

6. The record also contains progress notes dated November 25, 2002 of Stone Mountain Health Services' Nurse Practitioner Kellie Brooks. CX 5. Nurse Practitioner Brooks reported 22 to 23 years of coal mine employment, where Claimant stopped working in 1994 "due to health reasons and his lungs." Claimant noted a daily productive cough for ten years. He stated that he has "difficulty with steps and walking up hills." He becomes short of breath "after walking on level ground for 100 feet." Nurse Practitioner Brooks also noted that Claimant currently smokes and has smoked one pack of cigarettes per day for 35 years. Nurse Practitioner Brooks concluded that the miner suffered from chronic obstructive pulmonary disease. She also stated "Coal Worker for 3 years." This statement is unexplained. CX 5.

Nurse Practitioner Brooks graduated *cum laude* with a Bachelor's of Science in Nursing from Clinch Valley College of the University of Virginia. CX 5 at 3. She then received her Master's of Science in Nursing and Family Nurse Practitioner Certificate from the University of Virginia, where she held a 4.0 grade point average. Nurse Practitioner Brooks currently serves as Family Nurse Practitioner at Stone Mountain Health Services. She is also the clinician for the St. Charles Respiratory Care Center, where she provides physical examinations and pulmonary education to coal miners. She has received numerous honors and awards in her field. She is board-certified as a Family Nurse Practitioner by the American Nurses Credentialing Center. Nurse Brooks is also a NIOSH certified Spirometry Technician. CX 5 at 3.

7. Lastly, the record contains hospitalization records from February 8, 2003 to February 11, 2003 when the miner was hospitalized at the Russell County Medical Center for pneumonia. CX 4. Dr. Michael Ulrich prepared the discharge summary wherein he diagnosed Claimant with chronic obstructive pulmonary disease, coal workers' pneumoconiosis, bronchitis with purulent sputum, tobacco abuse, and elevated cardiovascular risk factors. A chest x-ray revealed "hyperlucency of the lungs, no clear infiltrate." Claimant was described as "afebrile" with dyspnea and wheezing. Oxygen therapy improved his status. Dr. Ulrich concluded that the "[m]ost important part of his care is that of quitting smoking," and it was noted that Claimant "seems to be set in his ways today about quitting smoking, will get the patch . . .." CX 4.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2005). In this case, Claimant's medical records indicate that he has been diagnosed with chronic obstructive pulmonary disease and emphysema, which can be encompassed within the definition of legal pneumoconiosis. Ibid.; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995). However, only chronic obstructive pulmonary disease or emphysema caused by coal dust constitutes legal pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003).

20 CFR § 718.202(a) (2005) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in Sections 718.304 (irrebuttable presumption of total disability due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners who died on or before March 1, 1978), or (4) a physician exercising sound medical judgment based on objective

medical evidence and supported by a reasoned medical opinion. There is no evidence that Claimant has had a lung biopsy, and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, he filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. Absent contrary evidence, evidence relevant to either category may establish the existence of pneumoconiosis. In the face of conflicting evidence, however, I must weigh all of the evidence together in reaching my finding whether the Claimant has established that he has pneumoconiosis. *U.S. Mining Co. v. Director, OWCP*, 386 F.3d 977 (11th Cir. 2004); *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000); *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22 (3rd Cir. 1997).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. See *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

The chest x-ray studies in this case have yielded positive and negative findings for the presence of pneumoconiosis. In cases with conflicting x-ray evidence, the regulations specifically provide,

> … where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 CFR § 718.202(a)(1) (2005); *Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-37 (1991). Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Sheckler v. Clinchfield Coal Co*., 7 B.L.R. 1-128, 1-131 (1984). A judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *see Adkins*, 958 F.2d at 52.

There are six studies submitted in conjunction with the miner's current claim. The December 10, 2002 study was interpreted by Dr. Ahmed, a dually-qualified physician, as

demonstrating Category 1 pneumoconiosis. On the other hand, another dually-qualified physician, Dr. Scott, concluded that the study revealed no parenchymal or pleural abnormalities consistent with the presence of pneumoconiosis. Dr. Ahmed, who has been dually-qualified since 1994, has served as Attending Radiologist at Princeton Community Hospital since 1982 as well as at the Bluefield Regional Medical Center since 1992. Dr. Scott graduated *magnum cum laude* from Harvard University with a *Bachelor of Arts* degree. He then received his medical degree from The Johns Hopkins University. Dr. Scott serves as Associate Professor of Radiology and Associate Professor of Orthopaedic Surgery at The Johns Hopkins Medical Institutions. He also serves as Associate Editor for *Radiology*, with regard to musculoskeletal conditions. He works on abstracts for the *Journal of Bone and Joint Surgery*. Dr. Scott has been a contributing author for several publications in his field. While Dr. Scott is a Professor of Radiology at the Johns Hopkins Medical Institutions, Dr. Ahmed has extensive experience serving as the Attending Radiologist at two medical facilities in the Princeton, West Virginia area. Both of these dually-qualified physicians are highly credentialed. However, because the Claimant bears the burden of demonstrating the presence of pneumoconiosis by a preponderance of the evidence, he has not sustained this burden as the readings and physicians' qualifications are in equipoise.

The January 15, 2003 study yielded a positive interpretation by Dr. Patel, a dually-qualified physician. However, Dr. Scatarige, who is also dually-qualified, found no evidence of coal workers' pneumoconiosis or silicosis on the study. Dr. Patel's *curriculum vitae* does not appear in the record. Dr. Scatarige was an honors graduate from the Temple University School of Medicine. He currently serves as Assistant Professor of Radiology at The Johns Hopkins University School of Medicine. He is a Staff Diagnostic Radiologist and a member of the Teaching Faculty at The Johns Hopkins Hospital. Dr. Scatarige has made numerous presentations and contributed to a variety of exhibits in his field. He has also presented several abstracts related to radiology and contributed to numerous publications and book chapters. Dr. Patel's *curriculum vitae* is not in the record. Consequently, based on the superior qualifications of Dr. Scatarige as an honors medical school graduate, radiology professor, and active diagnostic radiologist, this study does not support a finding of pneumoconiosis.

The March 12, 2003 study was interpreted by Dr. Miller, a dually-qualified physician, as demonstrating the presence of pneumoconiosis. Dr. Scott, who is also a dually-qualified physician, disagreed and concluded that the study did not produce parenchymal or pleural abnormalities consistent with pneumoconiosis. Dr. Miller graduated from the College of Physicians and Surgeons in 1986 with honors and completed a residency in diagnostic radiology. He serves as Assistant Clinical Professor of Radiology at the College of Physicians and Surgeons of Columbia University. He is also Chair of the Radiology Quality Improvement Committee. Dr. Scott's qualifications have been previously noted. Overall, Dr. Miller's qualifications are more impressive as he is an honors medical school graduate and a radiology professor as well as being actively involved with the Radiology Quality Improvement Committee. On balance, given Dr. Miller's superior credentials, I am persuaded that this study supports a finding of pneumoconiosis.

The April 30, 2003 study was interpreted by Dr. Ahmed, a dually-qualified physician, as demonstrating Category 1 pneumoconiosis. Another dually-qualified physician, Dr. Halbert,

marked the film as "completely negative." Dr. Ahmed's credentials have been previously noted. Dr. Halbert graduated from the University of Kentucky with a medical degree and performed his residency in diagnostic radiology there. Dr. Ahmed has superior credentials as an active Attending Radiologist at two medical facilities in the Princeton, West Virginia area. In addition, Dr. Halbert's finding that the study was "completely negative" is inconsistent with all of the other interpretations submitted in this subsequent claim; *to wit*, none of the other physicians found any of the films to be "completely negative." On balance, I am persuaded that this study supports a finding of pneumoconiosis.

Finally, the most recent two studies of record have been interpreted as negative for the presence of pneumoconiosis. Dr. Wiot, a dually-qualified physician, concluded that the December 4, 2003 study did not reveal parenchymal or pleural abnormalities consistent with the presence of pneumoconiosis. His interpretation remains uncontradicted and, therefore, this study does not support a finding of the disease. Dr. Wiot graduated from the University of Cincinnati College of Medicine. He has served on the American College of Radiology Task Force on Pneumoconiosis since 1969, including serving as Chair of the Committee for several years. Dr. Wiot has also served as a Radiological Consultant for the U.S. Public Health Service as well as Chair of the Workgroup of ILO Classification System from 1988 to 1990. Dr. Wiot has been a contributing author to several publications in his field and currently serves as a Consultant to the *Journal of Occupational Medicine.* He has served as a consultant to committees that address medical standards for diagnosing coal workers' pneumoconiosis.

Finally, Dr. Westerfield, a B-reader, concluded that the March 2, 2004 study was negative for the presence of pneumoconiosis and his interpretation is uncontradicted. Consequently, this study does not support a finding of pneumoconiosis.

These constitute all of the x-ray interpretations in the record pertaining to Claimant's subsequent claim. Overall, the weight of the negative x-ray interpretations by highly qualified physicians persuades me that the Claimant has not sustained his burden of demonstrating that he suffers from pneumoconiosis by a preponderance of the newly submitted chest x-ray evidence of record.[6] Three dually-qualified physicians found that the studies revealed the presence of pneumoconiosis. On the other hand, four dually-qualified physicians and a B-reader, including Dr. Wiot who assisted in the development of the ILO-U/C classification system for occupational lung diseases and has been extensively involved in the field for numerous years, concluded that the chest x-ray evidence did not support a finding of pneumoconiosis. On balance, I find that the Claimant has not demonstrated that he suffers from pneumoconiosis by a preponderance of the chest x-ray evidence.

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G*

[6] Notably, the May 27, 1997 study, which was conducted in conjunction with the Claimant's initial claim, was found by two B-readers, Drs. Gaziano and Forehand, to be completely negative.

Construction Co., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp*., 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co*., 6 B.L.R. 1-1182, 1-1184 (1984). An opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184, 186-187 (6th Cir. 1995); *Justice v. Island Creek Coal Co*., 11 B.L.R. 1-91, 1-94 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236, 1-239 (1984).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWC*P, 14 B.L.R. 1-2, 1-6 (1989). However, a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as the Claimant's treating physician. Rather, this is one factor which may be taken into consideration in … weighing … the medical evidence …" *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994). Factors to be considered in weighing evidence from treating physicians include the nature and duration of the relationship, and the frequency and extent of treatment. In appropriate cases, a treating physician's opinion may be give controlling weight, provided that the decision to do so is based on the credibility of the opinion "in light of its reasoning and documentation, other relevant evidence and the record as a whole." 20 CFR § 718.104(d) (2005). In this case, Mr. Thomas identified Dr. Sutherland as his current treating physician.

Factors to be considered in weighing evidence from treating physicians include the nature and duration of the relationship, and the frequency and extent of treatment. In appropriate cases, a treating physician's opinion may be give controlling weight, provided that the decision to do so is based on the credibility of the opinion "in light of its reasoning and documentation, other relevant evidence and the record as a whole." 20 C.F.R. § 718.104(d) (2005). In the final analysis, the credibility of the treating physician's opinion may primarily rest on its "power to persuade." *Eastover Mining Co. v. Williams*, 338 F.3d 501, 513 (6th Cir. 2003). In assessing the probative value of these conflicting opinions, I must account for "the qualifications of the respective physicians, the explanation of their medical opinions, the documentation underlying their medical judgments, and the sophistication and bases of their diagnoses." *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 441 (4th Cir. 1997). *See also*, *Clark v. Karst-Robbins Corp.* 12 B.L.R. 1-149 (1989) (en banc); *Lucostic v. United States Steel Corp.*, 8 B.L.R. 1-46 (1985). *Accord*, *Underwood v. Elkay Mining, Inc*.,105 F.3d 946, 950-951 (4th Cir. 1997).

I am mindful that an administrative law judge must consider a medical report as a whole, *see Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988), and *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984), and may not discredit an opinion merely because it is based on an x-ray interpretation which is outweighed by the other x-ray interpretations of record. *See Worhach v.*

Director, OWCP, 17 B.L.R. 1-105 (1993); *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986); *cf. Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111 (1989). Nevertheless, where x-ray evidence constitutes an apparent major part of the physician's documentation, his opinion may be entitled to diminished probative weight if that specific film has been reread as negative, and the administrative law judge makes a specific finding to that effect. *See generally Director, OWCP v. Rowe*, 710 F.2d 251, 255 n. 6 (6th Cir. 1983).

As the Court cautioned in *Underwood v. Elkay Mining, Inc*., 105 F.3d 946, 950-951 (4th Cir. 1997):

> In *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992), we pointed out that in considering expert opinions, merely 'counting heads' with the underlying presumption that two expert opinions ipso facto are more probative than one is a hollow endeavor and contributes little when weighing evidence. Id at 52. While we recognize that merely counting heads is not the appropriate manner for the ALJ to weigh numerous and diverse opinions, we did not suggest that two or three independent qualified opinions were necessarily of less probative value than one. In weighing opinions, the ALJ is called upon to consider their quality. Thus, the ALJ should consider the qualifications of the experts, the opinions' reasoning, their reliance on objectively determinable symptoms and established science, their detail of analysis, and freedom from irrelevant distractions and prejudices.…

In determining whether pneumoconiosis exists in this case, I must also consider the holding of the United States Court of Appeals for the Fourth Circuit in *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995) that "chronic obstructive lung disease … is encompassed within the definition of pneumoconiosis for the purpose of entitlement to Black Lung benefits." 60 F.3d at 175. The Court found that the assumptions of physicians that obstructive disorders cannot be caused by coal mine employment or that a diagnosis of pneumoconiosis cannot be made without x-ray or tissue samples to be erroneous. Citing *Eagle v. Armco, Inc*., 943 F.2d 509 (4th Cir. 1991), the Court noted that "the opinion of an expert 'that breathing coal mine dust does not cause chronic obstructive lung disease … must be considered bizarre in view of [ ] Congress' explicit finding to the contrary.'" 60 F.3d at 174-175 (Citations omitted).

In conjunction with the miner's subsequent claim, opinions by four physicians and one nurse practitioner have been submitted. Drs. Rasmussen and Sutherland as well as Nurse Practitioner Brooks conclude that the miner suffers from clinical and legal coal workers' pneumoconiosis. On the other hand, Drs. Rosenberg and Fino state that the miner's totally disabling lung disease is due solely to his long-term tobacco abuse.

Initially, with regard to the presence of clinical pneumoconiosis, the opinions of Drs. Rosenberg and Fino are more probative as they are better supported by a preponderance of the objective medical data of record, *i.e.* the preponderantly negative chest x-ray interpretations. *Minnich v. Pagnotti Enterprises, Inc.*, 9 B.L.R. 1-89, 1-90 n. 1 (1986).

However, the absence of clinical pneumoconiosis does not preclude a finding of legal coal workers' pneumoconiosis. This is supported by the regulations, which provide that

pneumoconiosis may be diagnosed in a reasoned medical opinion notwithstanding the presence of negative chest x-ray findings. 20 C.F.R. § 718.202(a)(4) (2005). Drs. Rasmussen, Sutherland, and Rosenberg and Nurse Practitioner Brooks agree that the miner suffers from totally disabling chronic obstructive pulmonary disease. Dr. Fino likewise finds the presence of a fixed, obstructive defect as well as pulmonary emphysema and chronic bronchitis that are totally disabling.[7] Thus, there is no dispute among the experts that the Claimant suffers from a totally disabling lung disease.

The issue becomes the cause of the disease. Importantly, the expert opinions in this case are based on similar medical findings and occupational and smoking histories. Examinations of the miner by all of the medical experts produced consistent findings of reduced breath sounds and, generally, rhonchi and/or wheezing. Moreover, all of the experts found a severe obstructive impairment with little improvement after use of a bronchodilator. Indeed, as set forth above, all of the ventilatory testing in this case produced qualifying values before and after use of a bronchodilator. Further, the values progressively worsened by the time of Dr. Fino's examination. Likewise, all of the physicians found that the miner's single carbon monoxide was markedly decreased, which reflected an inability to oxygenate blood. This is consistent with the miner's progressively worsening blood gas study values, which were qualifying after exercise in the beginning, but deteriorated at the time of Dr. Fino's examination to become qualifying at rest and after exercise. It is this inability to oxygenate blood that, according to Dr. Smiddy, necessitates the Claimant's use of oxygen 24 hours per day.

In rendering their opinions, all of the experts noted approximately 23 years of coal mine employment ending in July 1993 due to breathing difficulties. Moreover, they noted the miner has smoked one pack of cigarettes per day since around 14 or 16 years of age, and he continues to smoke. This constitutes a 38 pack year smoking history that is continuing.

Thus, the medical experts have premised their causation opinions on very similar medical data and work and smoking histories. Dr. Rasmussen cites to the miner's chronic productive cough, airflow obstruction, and reduced single breath carbon monoxide diffusing capacity in support of his conclusion that the miner's lung disease (emphysema and chronic obstructive pulmonary disease) was caused by coal dust exposure and smoking. He noted that both factors "share some of the same cellular and biochemical methods" in damaging lung tissue. This is consistent with the Department's position as set forth in the comments underlying the amended regulations.[8] Specifically, based on its review of available scientific data and literature, the Department states that:

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[7] I note that Dr. Iosif also found the presence of totally-disabling chronic obstructive pulmonary disease and pulmonary emphysema on examination of the miner in conjunction with his initial claim.

[8] It is not unusual for courts to cite to, and consider, published comments underlying the promulgation of regulations. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 156 n. 29 (1988) (favorable discussion of the Department's comments underlying promulgation of 20 C.F.R. § 727.203(a) to determine that the agency did not intend that a single piece of qualifying evidence be sufficient to invoke the interim presumption); *Consolidation Coal Co. v. Director, OWCP [Stein]*, 294 F.3d 885, 892 (7th Cir. 2002) (favorable consideration of the Department's December 2000 comments with regard to use of CT-scans in assessing the presence or absence of pneumoconiosis; it is proper to "defer to the Department of Labor's reasonable judgment in resolving complex, technical issues that draw upon its familiarity and expertise with the diagnosis, prevention, and remediation of black lung disease");

> . . . dust-induced emphysema and smoke-induced emphysema occur through similar mechanisms—namely, the excess released of destructive enzymes from dust- (or smoke-) stimulated inflammatory cells in association with a decrease on protective enzymes in the lung.

65 Fed. Reg. 79943 (Dec. 20, 2000).

Dr. Rasmussen's opinion is also supported by opinions of the miner's treating physician, Dr. Sutherland as well as Dr. Sutherland's consulting pulmonologist, Dr. Smiddy. Although Dr. Sutherland's opinion is accorded some weight because he has treated the miner since 1994, it is not entitled to controlling weight due to lack of adequate reasoning; his records document symptoms and worsening ventilatory dysfunction over a period of time, but his statement that the miner suffers from a coal dust induced disease is cursory. The same is true for Dr. Smiddy, who summarily concludes that the miner suffers from coal workers' pneumoconiosis despite a negative x-ray interpretation underlying his report. While a diagnosis of coal workers' pneumoconiosis may be made even in the presence of a negative chest x-ray interpretation, such a diagnosis must be adequately explained.[9]

In concluding that the miner's chronic obstructive pulmonary disease was due solely to his smoking history, Dr. Rosenberg stated the following:

> There is no question that coal mine dust exposure can cause COPD, and begins in and around the coal macule as focal emphysema develops. Subsequently, as coal workers' pneumoconiosis becomes more severe with the macule evolving into nodule formation, the associated COPD also can become more significant. With respect to Mr. Thomas, it would be improbable that his disabling COPD relates to the inhalation of past coal dust exposure, as his chest x-ray reveals no evidence of coal workers' pneumoconiosis. In fact, even if he had a minimal degree of simple coal workers' pneumoconiosis, his advanced disabling COPD . . . would not have been caused by this CWP. This type of 'end-stage' COPD only is associated with past coal dust exposure, if complicated CWP exists.

While Dr. Rosenberg's conclusion that coal dust exposure may cause chronic obstructive pulmonary disease is consistent with the regulations at § 718.201(a)(2) and Fourth Circuit case law, he concludes that negative chest x-ray findings render it "improbable" that coal dust exposure caused development of the miner's chronic obstructive pulmonary disease. He asserts that the type of "end stage" obstructive lung disease suffered by the Claimant "only is associated with past coal dust exposure, if complicated CWP exists." Dr. Rosenberg's opinion loses some probative force as he appears to focus on the fibrotic, or clinical, type of pneumoconiosis. The

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Bonessa v. United States Steel Corp., 884 F.2d 726, 729 (3rd Cir. 1989) (favorable referral to the Department's 1983 comments to 20 C.F.R. § 718.205(c) in assessing causation). Therefore, consideration of the Department's findings as set forth in the comments to the amended regulations is proper.

[9] Although Dr. Ulrich diagnosed coal workers' pneumoconiosis in the discharge report following the Claimant's February 2003 hospitalization, his conclusion is cursory and entitled to little probative value.

Department's position underlying the amended regulations, however, is that coal dust exposure may induce obstructive lung disease even in the absence of fibrosis or complicated pneumoconiosis. Citing to studies conducted by NIOSH, the Department states:

> COPD may be detected from decrements in certain measures of lung function, especially FEV1 and the ratio of FEV1/FVC. Decrements in lung function associated with exposure to coal mine dust are severe enough to be disabling in some miners, whether or not pneumoconiosis is also present.

65 Fed. Reg. 79943 (Dec. 20, 2000). The Department further notes:

> [A]lthough many of the studies evaluating mechanisms of pathogenesis of coal mine dust exposure concentrate on the development of fibrosis, there is considerable basic scientific data linking coal mine dust to the development of obstructive airways disease.

65 Fed. Reg. 79943 (Dec. 20, 2000). Dr. Rosenberg opines that end-stage chronic obstructive pulmonary disease, as is present in this case, is due to coal dust exposure only if complicated pneumoconiosis is present. This general premise is contrary to the Department's findings based on available scientific literature and studies and, as such, Dr. Rosenberg's opinion loses probative value.

Dr. Fino points to clinical findings of decreased breath sounds and wheezes, a severe fixed obstructive defect, a reduced diffusing capacity, and a marked increase in lung volumes as being consistent with his diagnosis of emphysema. He further states, however, that "[t]he oxygen desaturation and hypoxemia with exercise in conjunction with variable hypercarbia are all consistent with cigarette smoking induced lung disease." Accepting Dr. Fino's conclusion that the Claimant suffers from emphysema (which is consistent with Dr. Rasmussen's diagnosis), he fails to explain why the emphysema is due solely to the miner's history of tobacco abuse. The lack of reasoning with regard to the specific issue of the cause of the miner's emphysema renders Dr. Fino's opinion of little probative value. This is particularly so when compared to Dr. Rasmussen's reasoning, which is premised on a view of the development of coal dust and smoking induced respiratory ailments that is consistent with the Department's view.

Dr. Rasmussen's opinion is also buttressed by his superior credentials on this record. Drs. Rasmussen, Smiddy, Rosenberg, and Fino are board-certified in internal medicine. Dr. Fino is also board-certified in pulmonary diseases, Dr. Rosenberg is also board-certified in preventative medicine, and Dr. Rasmussen is also board-certified in forensic medicine. Of these highly qualified physicians, however, Dr. Rasmussen's *curriculum vitae* demonstrates that he has dedicated his medical career to occupational lung diseases in general and coal workers' pneumoconiosis in particular. As early as 1969, he was the recipient of the American Public Health Presidential Award for "exceptional service" in the area of black lung. Since then, Dr. Rasmussen has served on numerous federal and private task forces on the issue of coal workers' pneumoconiosis and he has testified before both houses of the United States Congress. Thus, Dr. Rasmussen offers a well-reasoned, well-documented opinion that is based on views consistent with those held by the Department and he has superior credentials on this record.

In sum, I do not discredit any of the medical opinions of record. In resolving the conflict presented by the physicians of record, however, I find the opinion of Dr. Rasmussen, as supported by the data and conclusions of Drs. Sutherland and Smiddy and Nurse Practitioner Brooks, to merit greater probative weight. This credible and well reasoned medical opinion is convincing for purposes of establishing that the Claimant suffers from coal workers' pneumoconiosis. This evidence outweighs the contrary conclusions provided by Drs. Rosenberg and Fino.

Notably, the preponderantly negative chest x-ray evidence does not detract from the well-reasoned, well-documented findings of legal coal workers' pneumoconiosis by Dr. Rasmussen, which is based on physical examination of the miner, symptoms, blood gas and ventilatory study data, and work and smoking histories and which is premised on views that are consistent with those of the Department. Indeed, the progressively worsening nature of the Claimant's impairment on pulmonary function and blood gas testing, lends further support to Dr. Rasmussen's conclusion that the miner's respiratory impairment is attributable to coal mining employment and smoking. I find that the Claimant has met his burden of showing that he has a coal dust induced pulmonary or respiratory disease.

Because the provisions of § 725.309 require that the entire record be reviewed *de novo* as the Claimant has demonstrated that he suffers from legal coal worker's pneumoconiosis, the only opinion remaining for consideration is the report of Dr. Iosif. As with opinions submitted in conjunction with the miner's subsequent claim, Dr. Iosif concluded that the miner suffered from a totally disabling obstructive lung disease. He attributed this condition solely to the miner's history of tobacco abuse. However, Dr. Iosif's conclusion is unpersuasive because it is conclusory when compared to the more recent, well-reasoned report of Dr. Rasmussen. Moreover, although Dr. Iosef is board-certified in internal medicine and pulmonary diseases, for reasons previously stated, Dr. Rasmussen's credentials are superior.

Total Pulmonary or Respiratory Disability

As noted above, the Fourth Circuit standard for review of a subsequent claim requires that the entire record be considered if a claimant establishes one of the elements of entitlement previously decided against him.

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304 (2005), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c) (2005). The regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 CFR § 718.204(b) and (d) (2005). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 CFR § 718.204(d) (2005); *Tedesco v. Director, OWCP*, 18 B.L.R.

1-103, 1-106 (1994). There is no evidence in the record that suffers from complicated pneumoconiosis or cor pulmonale. Thus, I will consider pulmonary function studies, blood gas studies and medical opinions. In the absence of contrary probative evidence, evidence from any of these categories may establish disability. If there is contrary evidence, however, I must weigh all the evidence in reaching a determination whether disability has been established. 20 CFR § 718.204(b)(2) (2005); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986).

Initially, it is noted that the Claimant has demonstrated a totally disabling pulmonary impairment based on the newly submitted pulmonary function study evidence. Indeed, all of the ventilatory studies produced qualifying values and physicians conducting the studies unanimously opined that the studies demonstrated the presence of a severe obstructive defect.[10] This is consistent with the qualifying values obtained from Dr. Iosif's ventilatory test conducted in conjunction with the miner's initial claim. Thus, the Claimant has established a totally disabling pulmonary impairment under § 718.204(b)(2) of the regulations.

Turning to the blood gas testing of record, results obtained while resting during the January, April, and June 2003 tests were non-qualifying and would not support a finding of total disability.[11] However, the January and June 2003 tests also included values obtained after exercise and, on both occasions, these values were qualifying. Moreover, the most recent blood gas study of record, conducted by Dr. Fino on December 4, 2003, produced qualifying values at rest and after exercise. As is discussed *infra*, the Claimant's last job as a roof bolter constituted heavy manual labor. The blood gas testing demonstrates that the miner is unable to adequately oxygenate blood and, indeed, the testing reveals that his condition is worsening such that, by the time of Dr. Fino's examination, the miner's values were qualifying at rest as well as exercise. Based on the foregoing, I find that the Claimant has demonstrated a totally disabling respiratory impairment through a preponderance of the blood gas testing under § 718.204(b)(2) of the regulations.

Finally, the medical opinion evidence also supports a finding that the Claimant suffers from a totally disabling respiratory impairment. The Claimant testified that he last worked as a roof bolter. This job required that he drill the top of the mine tunnel, insert a metal place, and drill two bolts on each side of the plate to keep it in place. The bolts weighed one to two pounds each and he worked in low coal, which required that the miner bend over while working. He also crawled during his shift. I find that the Claimant engaged in heavy manual labor.

All physicians who examined the Claimant or reviewed his records agree that the Claimant has a severe obstructive impairment and that he could not perform the duties of his last job as a roof bolter. Their opinions are supported by a preponderance of the objective medical data, *i.e.* preponderantly qualifying ventilatory and blood gas testing. *See Minnich, supra*. There is no contrary medical opinion of record and, as a result, I find that the expert opinions provide a

[10] The February 2004 study also yielded qualifying values, but it is not probative of the miner's true lung function as Dr. Long invalidated the study for less than optimal effort.

[11] This is consistent with the non-qualifying resting results obtained by Dr. Iosif during blood gas testing conducted as part of the miner's initial claim.

reasoned and documented finding that the miner suffers from a totally disabling respiratory impairment.

Causation of Total Disability

In order to be entitled to benefits, the Claimant must establish that pneumoconiosis is a "substantially contributing cause" to his disability. A "substantially contributing cause" is one which has a material adverse effect on the miner's respiratory or pulmonary condition, or one which materially worsens another respiratory or pulmonary impairment unrelated to coal mine employment. 20 CFR § 718.204(c) (2005); *Hobbs v. Clinchfield Coal Co*., 917 F.2d 790, 792 (4th Cir. 1990); *Robinson v. Pickands Mather & Co*., 914 F.2d 35, 38 (4th Cir. 1990).

The Benefits Review Board has held that Section 718.204 places the burden on the claimant to establish total disability due to pneumoconiosis by a preponderance of the evidence. *Baumgardner v. Director, OWCP*, 11 B.L.R. 1-135 (1986). Nothing in the commentary to the new rules suggests that this burden has changed; indeed, some language in the commentary indicates it has not changed. See 65 Fed. Reg. at 79923 (2000) ("Thus, a miner has established that his pneumoconiosis is a substantially contributing cause of his disability if it either has a material adverse effect on his respiratory or pulmonary condition or materially worsens a totally disabling respiratory or pulmonary impairment …"). The Fourth Circuit requires that pneumoconiosis be a "contributing cause" of the miner's disability. *Hobbs v. Clinchfield Coal Co*., 917 F. 2d 790, 791-792 (4th Cir. 1990). In *Toler v. Eastern Associated Coal Co*., 43 F.3d 109 (4th Cir. 1995), the Court found it "difficult to understand" how an Administrative Law Judge (ALJ), who finds that the claimant has established the existence of pneumoconiosis, could also find that his disability is not due to pneumoconiosis on the strength of the medical opinions of doctors who had concluded that the claimant did not have pneumoconiosis. The Court noted that there was no case law directly in point and stated that it need not decide whether such opinions are "wholly lacking in probative value." However the Court went on to hold:

> Clearly though, such opinions can carry little weight. At the very least, an ALJ who has found (or has assumed arguendo) that a claimant suffers from pneumoconiosis and has a total pulmonary disability may not credit a medical opinion that the former did not cause the latter unless the ALJ can and does identify specific and persuasive reasons for concluding that the doctor's judgment on the question of disability does not rest upon her disagreement with the ALJ's finding as to either or both of the predicates in the causal chain.

43 F.3d at 116. *See also Scott v. Mason Coal Company*, 289 F.3d 263, 269-270 (4th Cir. 2002).

In this case, because (1) all of the physicians agree that the miner suffers from a totally disabling lung impairment; and (2) I have determined that this lung disease stemmed, at least in part, from coal dust exposure, then it reasonably follows that coal dust exposure was a "substantially contributing cause" of the miner's total disability. Indeed, Dr. Rasmussen opined that the miner's totally disabling lung impairment stems, in part, from coal dust exposure and, as previously noted, this is supported by the opinions of Drs. Sutherland and Smiddy and Nurse Practitioner Brooks. Dr. Fino maintains that:

> Even if chronic obstructive lung disease due to coal mine employment contributed to the obstruction, the loss in the FEV1 would be in the 200 cc range. If we gave back to him that amount of FEV1, this man would still be disabled. This medical estimate of loss in FEV1 in working miners was summarized in the 1995 NIOSH document. Although a statistical drop in the FEV1 was noted in working miners, that drop was not statistically significant.

EX 2. Thus, he concluded that, even if it was assumed that coal workers' pneumoconiosis was present, it did not contribute to Claimant's disability. First, Dr. Fino's opinion is accorded less weight because, although he references a "1995 NIOSH document" in support of his statement, the document is not in the record. Second, a similar position presented by Dr. Fino during the Department's rulemaking proceedings, *i.e.* that coal dust exposure would not cause a significant decrease in the FEV1 values on testing, was rejected. *See* 65 Fed. Reg. 79938-41 (Dec. 20, 2000). Specifically, the Department concluded that there is "a statistically significant association between cumulative dust exposure and decline in lung function." 65 Fed. Reg. 79939 (Dec. 20, 2000). Moreover, the Department noted that "[s]mokers who mine have additive risk for developing significant obstruction." 65 Fed. Reg. 79940 (Dec. 20, 2000). Thus, Dr. Fino's bald assertion that the loss of FEV1 in working miners is not statistically significant is without empirical support in this record and is contrary to the Department's position.

Date of Entitlement

In the case of a miner who is totally disabled due to pneumoconiosis, benefits commence with the month of onset of total disability. Where the evidence does not establish the month of onset, benefits begin with the month that the claim was filed. 20 CFR § 725.503(b) (2005). The Claimant filed his claim for benefits in July 2002. When he was examined by Dr. Rasmussen in February 2003, he was already totally disabled. The regulation regarding subsequent claims also provides, however, that "[i]n any case in which a subsequent claim is awarded, no benefits may be paid for any period prior to the date upon which the order denying the prior claim became final." 20 CFR § 725.309(d)(5). The District Director issued his proposed decision and order on Mr. Thomas' prior claim on July 15, 1997. As Mr. Smith took no further action on that claim, it became final one year later, on July 15, 1998. There is no evidence of record generated between the date the initial claim was finally denied and Dr. Rasmussen's February 2003 opinion that enables me to pinpoint the precise date on which the Claimant became totally disabled due to pneumoconiosis. I therefore find that the Claimant is entitled to benefits commencing in July 2002, the month in which he filed his claim.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Having considered all of the relevant evidence, I find that the Claimant has established that he has pneumoconiosis arising out of his coal mine employment, and a totally disabling pulmonary or respiratory impairment caused by pneumoconiosis. Thus the Claimant has met his burden of showing a change in an applicable condition of entitlement pursuant to § 725.309(d). Accordingly, the Claimant is entitled to benefits under the Act.

REPRESENTATIVE'S FEES

The regulations address non-attorney representatives' fees at 20 CFR §§ 725.362, 365 and 366 (2005). The Claimant's representative has not yet filed an application for fees. The Claimant's representative is hereby allowed thirty days (30) days to file an application for fees. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. The parties (including the Claimant) have ten days following service of the application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim for benefits filed by Ronnie S. Thomas on July 10, 2002, is hereby GRANTED.

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ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is:

Benefits Review Board
U.S. Department of Labor
P.O. Box 37601
Washington, DC 20013-7601

Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481. If an appeal is not timely filed with the Board, the administrative law

judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).